STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155233	A. BUILDING _____ B. WING _____	03/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF BATESVILLE, THE	958 E HWY 46 BATESVILLE, IN47006

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F0000	This visit for the Investigation of Complaint IN00086624. Complaint IN00086624 - Substantiated. Federal/State deficiencies related to the allegations are cited at F223, F225 and F226. Survey dates: March 7, 8, and 9, 2011. Facility number: 000138 Provider number: 155233 AIM number: 100266500 Survey team: Penny Marlatt, RN Census bed type: SNF/NF: 73 Total: 73 Census payor type: Medicare: 6 Medicaid: 49 Other: 18 Total: 73 Sample: 5 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Quality review 3/15/11 by Suzanne Williams, RN			

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F0223 SS=D	Based on interview and record review, the facility failed to ensure 1 of 5 residents reviewed for abuse in a sample of 5 were safe from verbal abuse by a facility staff nurse. (Resident A) Findings include: Resident A's clinical record was reviewed on 3-7-11 at 3:42 p.m. His diagnoses included, but were not limited to, cerebrovascular accident (stroke), right sided spastic hemiplegia (paralysis), peripheral vascular disease (poor circulation), anxiety, depression, and dysphagia (difficulty swallowing). Resident A's most recent Minimum Data Set (MDS) assessment, dated 12-23-10, indicated an inability to recall 3 words after 5 minutes and could not recall the current year within a 5 year time frame. The MDS did indicate the ability to recall 3 words when asked immediately after being provided the words, the current day of the week and the current month. It did not indicate any behavioral issues. It indicated he is unable to walk, requires extensive assistance of 1-2 persons with transfers from one surface to another, is able to feed himself with set up assistance and has impairment of one side which affects his range of motion (arm and leg	F0223	F223 Protect from abuse It is the intent of this facility to ensure that all residents are safe from verbal abuse from staff. Actions Taken: The employee involved was terminated prior to the survey. Residents identified: A 100% audit of all alert and oriented residents was done. No other residents were identified. Measures Taken: Refer to “Actions Taken.” In-services conducted for all staff related to abuse policy/procedure March 18 through March 24, 2011 including priority of protecting residents from any further potential abuse, i.e. removing accused personnel from the facility during the investigation, etc. How Monitored: Administrator or Designee will review all abuse investigations as any occur for on-going compliance with policy/procedure for abuse protocol in daily QA. Administrator or Designee will review all investigations during daily QA meeting to ensure and be responsible for on-going compliance.	04/06/2011

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	use) of both upper and lower extremities. It indicated he uses a wheelchair for mobility. In an interview with the DON on 3-7-11 at 3:45 p.m., she indicated an initial allegation [of abuse] came from two dietary staff on 2/11/11. The allegation was that a nurse had taken Resident A out of the dining room, told him he had been in the dining room too long, that he was ready to be done and that he should not have been sleeping through lunch. She indicated the two statements differed "some." She indicated one statement indicated Resident A had eaten his dessert, but was unsure of what else was eaten, but that he wanted more coffee. She indicated this report indicated the nurse spoke in a very stern manner and scolded him about his eating and his position in the chair. The DON indicated the other report indicated Resident A was still eating when RN #5 pulled his wheelchair away. She indicated the Administrator spoke with the resident who indicated he was done eating and didn't want anything else. She indicated Resident A's "memory is poor." The DON indicated she spoke with RN #5. She indicated RN #5 indicated to her the resident was finished eating and she told him he could not take the coffee with him in the nosey cup because it might		This will be reviewed with Medical Director at Quarterly QA meeting. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is April 6, 2011	

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	spill, so she put it on the medicine cart and took it back to the floor for him. She indicated the nurse indicated another resident was having problems and she needed to get back on the floor. In a written statement, dated 2-11-11, from dietary staff #3, she indicated she was cleaning in the dining room after lunch when she "heard [name of RN #5] say [name of resident] this is your structure time and you need not to be sleeping, you should be eating, now time for your eating is up. You should stop sleeping and eat instead." The statement indicated RN #5 spoke to Resident A, "in a very unfriendly and firm way as if she was scolding him." The statement indicated RN #5 then pulled him away from the table. The statement indicated dietary staff #3 asked Resident A if he would like his coffee and she provided a covered coffee cup for him. The statement indicated RN #5 then indicated, "I don't know why you got that coffee, you aren't taking that back to your room." The statement indicated this "was not said in a very nice way, very stern and rough." In an interview with dietary staff #3 on 3-8-11 at 10:30 a.m., she indicated the written report she had provided to the facility was correct. She indicated RN			

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	#5's voice was loud and gruff. She indicated she had heard this particular nurse speak in "what I would call a rough manner, but never so loud or belligerent. Different than normal." She indicated Resident A would usually answer back [when spoken to], but did not say anything [to RN #5,] which was different than usual for him. She indicated the coffee was placed in a regular travel mug with a lid, not a nosey cup. She indicated she was in the other half of the dining hall when she heard the nurse speaking to Resident A. She indicated by the time she got over to the resident, RN #5 had removed his bowls and taken them to the dirty [dish] window, so that was why she was uncertain what he had eaten. In an undated written statement, from dietary staff #4, she indicated she was cleaning in the dining room after lunch on 2-11-11, when she observed RN #5 pull Resident A's wheelchair away from the table while he was still eating. The statement indicated RN #5 indicated to the resident that he was done eating because he'd eaten for over an hour, that he was on a schedule and he needed not to sleep through meals. The statement indicated Resident A indicated, "Bull s--t." The statement indicated dietary staff #4 observed RN #5 remove his bib (sic)			

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	then took Resident A out into the hallway "Still arguing with him over eating and sleeping." In an interview with dietary staff #4 on 3-8-11 at 10:45 a.m., she indicated the written report she had provided to the facility was correct. She indicated she was in the dining room one table away from Resident A. She indicated RN #5 "spoke in a loud, rude tone. Can't say I had heard her speak in that tone before. I told them [facility administration] it was a tone that would have upset me...I've heard her be stern before, but it was more rude than stern." She indicated Resident A usually uses a traveler's mug for his coffee and he still had that. She indicated Resident A still had his divided plate and it looked like he had barely touched his food, but could not recall if he had eaten his dessert. She indicated RN #5 stood in front of the resident and let him know he was done with his meal. She indicated RN #5 then took his silverware and cup out of his hand, told him he was on a schedule and didn't need to be sleeping. In a written statement, dated 2-11-11, from RN #5, she indicated at 12:55 p.m. she returned to the dining room to find Resident A and several other residents with no nursing staff that she could see			

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	present. The statement indicated after providing assistance to another resident, she pulled Resident A away from the table slowly due to him "sliding out of his chair." The statement indicated she repositioned him in his wheelchair "and said it was time to go. He growled at me." It indicated RN #5 then assisted another resident and while she did this, Resident A returned to his table and "grabbed his coffee and was proceeding toward the hall." The statement indicated, "I said to him, 'You shouldn't take that down the hallway, it spills and makes a mess.'" The statement indicated RN #5 indicated the resident began to drink the coffee and spill it onto his shirt and she indicated to the resident, "Come on, let's go. I need to get back and take care of someone who needs me." The statement indicated the resident continued to drink and spill coffee and she indicated to the resident, "Please give the cup it's spilling. You can have it back at the nurse's station." The statement indicated RN #5 then placed the cup on the medicine cart and pushed the medicine cart down the hall. In interview with the DON on 3-7-11 at 4:45 p.m., she indicated the facility continued their investigation and RN #5 was suspended for about 1 week during			

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	the investigation. She indicated the facility determined they were uncertain of exactly what had happened. She indicated the facility looked into "the entire situation, including how we did things at meals." She indicated RN #5 "did come back to work for a short while with new work guidelines. She did not fulfill them and was let go last week." She indicated RN #5 was a smoker and had a raspy voice which can sometimes sound a little harsh even when it is not meant that way. She indicated, "Because of her job performance, she is no longer here." She indicated a report was sent to the Indiana State Department of Health (ISDH). In an interview with the DON on 3-9-11 at 3:10 p.m., she indicated RN #5 had received two previous [job performance] "write ups" in regard to medication errors, one in May 2010 and one in July 2010. The DON indicated she could not find the documentation regarding the July 2010 write up. An additional "90 Day Performance Improvement Plan," dated 11-15-10, indicated the facility had identified RN #5 as "displaying some behavior that has been noticed as being hostile, intimidating or rude, as well as exhibiting a level of distraction and inattention to detail, which has been creating an uncomfortable environment			

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	within your work group." The document provided a plan of correction and coaching. A secondary document, with the same name, dated 2-15-11, indicated an improvement in the areas of nursing practice, verbal communication with subordinates, peers, residents and visitors and supervision of certified nursing assistants. The document did not indicate any information regarding the abuse allegation of 2-11-11 or its ongoing investigation. A written statement from the Administrator, dated 2-11-11 at 1:30 p.m., indicated the Administrator had interviewed Resident A in regard to the abuse allegation on the same date. The statement indicated Resident A had eaten lunch, was not still hungry, that he thought he had eaten enough, that no one had spoken to him or treated him in an inappropriate manner. In a follow-up interview, located in the social services section of the clinical record, with Resident A on 2-15-11 with no time listed , the social services staff #1 indicated the resident indicated he was finished with his meal and felt he was not spoken to harshly. A policy entitled, "Abuse Prohibition" with an issue date of 6-1-10 and provided			

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	by the DON on 3-7-11 at 11:40 a.m., indicated, "It is the intent of this facility to maintain an environment free of abuse and neglect...Residents will not be subjected to such events by anyone including, but not limited to facility staff..." The policy indicated the definition of verbal abuse as, "The use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability." An "Incident Documentation and Investigation Tool" document, dated 2-11-11, indicated an "allegation" occurred on 2-11-11 at 1:00 p.m. in the dining room. The document did not indicate what type of allegation had occurred, however the sections for "Fall,""Skin Tears/Bruise/Laceration/Abrasion/Contusion," and "Resident to Resident Altercation/Elopement" were marked out. It indicated the physician was notified at 4:35 p.m. by fax and the family notified at 4:45 p.m. by message. It indicated, "Staff suspended, CEO (chief executive officer) notified" under the section entitled, "What was done immediately." In the area of "Immediate Actions," it indicated "Staff			

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	suspended, investigation begun." This federal tag relates to complaint IN00086624. 3.1-27(a)(1) 3.1-27(b)			

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F0225 SS=D	Based on interview and record review, the facility failed to ensure reports regarding abuse allegations were forwarded to the Indiana State Department of Health in a timely manner. This deficient practice affected 2 of 5 residents reviewed for abuse in a sample of 5. (Residents A and E) Findings include: 1. In an interview with the DON on 3-7-11 at 3:45 p.m., she indicated an initial allegation [of abuse] came from two dietary staff on 2-11-11 regarding Resident A. The allegation was that a nurse had taken Resident A out of the dining room, told him he had been in the dining room too long, that he was ready to be done and that he should not have been sleeping through lunch. In interview with the DON on 3-7-11 at 4:45 p.m., she indicated the facility did an investigation of the events of 2-11-11 and sent a report to the Department of Health. A copy of a document entitled "Facility Incident Reporting Form" was provided by the DON on 3-8-11 at 12:15 p.m. and indicated this was an initial report for the incident with Resident A on 2-11-11 at 1:00 p.m. The accompanying document	F0225	F225 Investigate/report allegations/individuals It is the intent of this facility to have all reports involving abuse reported per the requirements to ISDH and in a timely manner. Actions Taken: In regards to Resident A, it was reported a day late. Resident E was reported two hours late. Residents Identified: no other residents were identified. Measures Taken: Refer to “Actions Taken.” The Administrator and the Director of Nursing were in-serviced regarding reporting timely March 25, 2011 by Kim Scott, RN, BS, QR Supervisor from Corporate Office . An in-service was conducted for all staff related to abuse policy/procedure and reporting timely March 18 through March 24 by Karen Centers, RN. How Monitored: Administrator or Designee will review abuse investigations as any occur to ensure compliance with policy/procedure for abuse protocol and reporting timely. Administrator or Designee will review all investigations daily in QA meeting to ensure and be	04/06/2011

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	with this indicated the incident report had been electronically mailed to the Indiana State Department of Health (ISDH) on 2-13-11 at 12:53 p.m. 2. In an interview on 3-8-11 at 8:30 a.m. with the DON and the Administrator, the DON indicated the previous evening, 3-7-11 between 5:45 p.m. and 7:15 p.m., the family of Resident E alleged abuse of RN #6 in which RN #6 intentionally aggravated Resident E which contributed to the resident having behaviors and being sent out of the facility for a psychiatric evaluation. The DON indicated an investigation was initiated with RN #6 currently on suspension, pending the results of the investigation. The DON indicated, "We will make sure this gets reported to ISDH by 7:15 this evening." A copy of a document entitled "Facility Incident Reporting Form" was provided by the DON on 3-9-11 at 3:10 p.m. and indicated this was an initial with follow-up report for the incident with Resident E on 3-7-11 at 7:35 p.m. The accompanying document with this indicated the incident report had been electronically mailed to ISDH on 3-8-11 at 9:20 p.m. In an interview with the DON on 3-9-11		responsible for on-going compliance. This will be reviewed with Medical Director at Quarterly QA meeting. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is April 6, 2011.	

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	at 3:10 p.m., she indicated, "Yes I think both reports (name of Resident A and Resident E) were more than 24 hours after the fact. I thought it was okay as long as it was before the next business day started. Yes, the dates and times listed on the email are correct." A policy entitled, "Reportable Unusual Occurrence" with an issue date of 6-1-10 and provided by the DON on 3-7-11 at 11:40 a.m., indicated, "Facilities are required by law to report unusual occurrences within 24 hours of occurrence to the Long Term Care Division" [of the ISDH]. This federal tag relates to complaint IN00086624. 3.1-28(c) 3.1-28(e)			

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F0226 SS=D	Based on interview and record review, the facility failed to ensure its abuse prevention policy and procedure was implemented, regarding investigation of allegations and reporting allegations to the Indiana State Department of Health in a timely manner. This deficient practice affected 2 of 5 residents reviewed for abuse in a sample of 5. (Residents A and E) Findings include: 1. In an interview on 3-8-11 at 8:30 a.m. with the DON and the Administrator, the DON indicated the previous evening, 3-7-11 between 5:45 p.m. and 7:15 p.m., the family of Resident E alleged abuse by RN #6 in which RN #6 intentionally aggravated Resident E which contributed to the resident having behaviors and being sent out of the facility for a psychiatric evaluation on 3-2-11. The DON indicated an investigation was initiated with RN #6 currently on suspension, pending the results of the investigation. The DON indicated, "We will make sure this gets reported to ISDH by 7:15 this evening. In an interview on 3-9-11 at 12:25 p.m. with the DON and the Corporate Nurse, the DON indicated, "None of us were	F0226	F226 Develop and Implement Abuse/Neglect/etc. policies. It is the intent of this facility to follow/implement our abuse prevention policy and procedure regarding investigations of allegation and reporting allegations to ISDH in a timely manner. Actions Taken: Administrator and Director of Nursing were in-serviced on Abuse policy/procedure implementation March 25, 2011 by Kim Scott, RN, BS, QR Supervisor from Corporate Office regarding investigation and reporting allegations to ISDH in a timely manner. Residents Identified: Resident A reported one day late. Resident E reported two hours late. Measures Taken: Refer to “Actions Taken.” An in-service was conducted for all staff related to abuse policy/procedure and reporting timely March 18 through March 24 by Karen Centers, RN. How Monitored: Administrator or Designee will review abuse investigations as any occur to ensure compliance with policy/procedure for abuse protocol and reporting in a timely manner. Administrator or Designee will review all investigations during daily QA meeting to ensure and be responsible for on-going compliance.	04/06/2011

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	155233	A. BUILDING _____ B. WING _____	03/09/2011

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	aware until 3-7-11 when she (LPN #7) got written up that she was reporting this situation as abuse, because in our conversations, she told me she was not reporting it as abuse" [referring to the incident with Resident E on 3-2-11). In an undated statement, signed by the DON, it indicated on 3-2-11 at 7:54 am., she received a [phone] call from LPN #7 in which LPN #7 indicated that she was upset because RN #6 had been rude to her and yelled at her. She indicated LPN #7 was crying and that LPN #7 was not reporting abuse, but RN #6 had done the wrong thing. The DON indicated LPN #7 indicated to her, "I'm not calling to report this as abuse, (name of RN #6) told me to call you if I thought she was wrong." She indicated LPN #7 indicated a third time during the phone conversation that she was not reporting abuse and indicated that RN #6 should not have stopped Resident E from coming in the dining room. In a written statement, dated 3-2-11 at 8:25 a.m. and signed by LPN #7, she indicated what she had seen and heard in the main dining room involving Resident E, RN #6, social services staff #1 and unnamed CNAs. She indicated RN #6 indicated to her that she needed to report "the abuse" (type and to whom		This will be reviewed with Medical Director at Quarterly QA meeting. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is April 6, 2011.	

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	unspecified) to the DON. She indicated that she then left the dining room and called the DON, who told her to take a few minutes and write down what she saw and heard. In a phone interview with LPN #7 on 3-9-11 at 9:59 a.m., she indicated on 3-2-11 that she was working in the main dining room when she heard and saw the interaction between Resident E and RN #6. She indicated that after the resident was removed from the dining room, RN #6 indicated to her that if I thought this [situation] was abuse, then I could report it to the DON and she indicated she did in a phone call a few minutes before 8:00 a.m. In an interview with the Corporate Nurse on 3-9-11 at 12:25 p.m., she indicated the DON "should have begun a full investigation when she got (name of LPN #7)'s written statement with the term abuse. But she went by (name of LPN #7)'s verbal statement, several times that is, that she was not reporting abuse." A copy of a document entitled "Facility Incident Reporting Form" was provided by the DON on 3-9-11 at 3:10 p.m. and indicated this was an initial with follow-up report for the incident with			

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	Resident E on 3-7-11 at 7:35 p.m. The accompanying document with this indicated the incident report had been electronically mailed to ISDH on 3-8-11 at 9:20 p.m. 2. In an interview with the DON on 3-7-11 at 3:45 p.m., she indicated an initial allegation [of abuse] came from two dietary staff on 2-11-11 regarding Resident A. The allegation was that a nurse had taken Resident A out of the dining room, told him he had been in the dining room too long, that he was ready to be done and that he should not have been sleeping through lunch. In interview with the DON on 3-7-11 at 4:45 p.m., she indicated the facility did an investigation of the events of 2-11-11 and sent a report to the Department of Health. A copy of a document entitled "Facility Incident Reporting Form" was provided by the DON on 3-8-11 at 12:15 p.m. and indicated this was an initial report for the incident with Resident A on 2-11-11 at 1:00 p.m. The accompanying document with this indicated the incident report had been electronically mailed to the Indiana State Department of Health (ISDH) on 2-13-11 at 12:53 p.m.			

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	In an interview with the DON on 3-9-11 at 3:10 p.m., she indicated, "Yes I think both reports (name of Resident A and Resident E) were more than 24 hours after the fact. I thought it was okay as long as it was before the next business day started. Yes, the dates and times listed on the email are correct." A policy entitled, "Abuse-Response to Suspected " with an issue date of 6-1-10 and provided by the DON on 3-7-11 at 11:40 a.m., indicated, "All allegations of abuse must be taken seriously and must be investigated." Under the heading of "Procedures" for this policy, Step #2, it indicated, "If the allegation is related to physical, verbal...abuse of a resident, the Administrator, or designee or staff member present at the time of the allegation will take immediate steps to prevent further potential abuse while the investigation is in process..." In step #7 of this policy, it indicated, "If the suspected perpetrator is an employee of the facility, he/she will be suspended until the investigation has been completed or otherwise in accordance with employee policies." A policy entitled, "Reportable Unusual Occurrence" with an issue date of 6-1-10 and provided by the DON on 3-7-11 at			

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	11:40 a.m., indicated, "Facilities are required by law to report unusual occurrences within 24 hours of occurrence to the Long Term Care Division" [of the ISDH]. This federal tag relates to complaint IN00086624. 3.1-28(a) 3.1-28(c) 3.1-28(e)			